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Dermatology Coding Alert

Diagnosis Coding: Follow These 4 Steps to Master 940-949 Burn Diagnoses

Proper ICD-9 coding for burn patients can require several codes.

Dermatology coders who cannot choose the proper diagnosis codes for each burn treatment patient could end up costing their practices time and money.

How? Let's say your dermatologist provides local burn treatment for a patient (16000, Initial treatment, first degree burn, when no more than local treatment is required). If the claim contains an inaccurate burn diagnosis code, or no diagnosis code at all, the insurer could deny claims for burn treatment based on lack of medical necessity. Snuff out potential denials by following these four quick steps to picking the perfect burn diagnosis codes for each burn treatment encounter.

Step 1: Check Notes for Location of Burn

When choosing a burn diagnosis code, you first need to check the anatomic location of the burn, confirms **Kevin Arnold, CPC,** director of compliance for LYNX Medical Systems, based Washington. If you have notes indicating the anatomy of the burn, you'll first choose a burn diagnosis code from the 940.x (Burn confined to eye and adnexa ...) to 947.x (Burn of internal organs ...) code set.

The first three digits of the 940.x-947.x codes "refer to the general anatomic location of the burn. The fourth digit refers to the degree of the burn, with the fifth digit being the most specific anatomic location of the group," says Arnold. Not all of the codes in this diagnosis set have fifth-digit requirements, but you must code to the fifth digit if the code specifies it.

Example: The dermatologist treats a patient with first degree burns on his left foot. On the claim, you would report 945.12 (Burn of lower limb[s]; erythema [first degree]; foot) to represent the patient's condition.

If you have no evidence of burn location in the notes, choose a code from the 949.x code set instead, explains **Jeffrey Linzer Sr., MD, FAAP, FACEP,** Associate Medical Director for Compliance, Emergency Pediatric Group, Children's Healthcare of Atlanta at Egleston.

For example, operative notes indicate that a patient suffered second-degree burns, but there is no indication as to the anatomical location of the burn. For this claim, you would choose 949.2 (Burn, unspecified; blisters, epidermal loss [second degree]) as a diagnosis code.

Step 2: Ensure You've Coded for All Burns

You'll also need to make sure that you are coding for each burn the patient suffered. How many codes you include to represent the patient's injuries depends on encounter specifics.

Submit single Dx when ... you are coding for multiple burns of the same severity in the same anatomic location, explains Arnold. For example, if notes indicate a patient suffered second-degree burns to his thumb and forefinger, you'd choose 944.24 (Burn of wrist[s] and hand[s]; blisters, epidermal loss [second degree]; two or more digits including thumb) as a diagnosis.

You might also take advantage of the "multiple sites" fifth-digit diagnosis option when possible -- though not every code in the 940.x-947.x diagnosis code set affords you that luxury. Let's say that notes indicate first-degree burns on a patient's chin, nose and scalp. For this patient, you'd choose 941.19 (Burn of face, head, and neck; erythema [first

degree]; multiple sites [except with eye] of face, head, and neck) as a diagnosis code.

Submit multiple Dx codes when ... the burns are of differing severity, are in different anatomical locations, or both. When submitting diagnosis codes for patients with multiple burns of differing severities, list the code for the most severe burn first, confirms Linzer. Consider the following pair of examples:

Example 1: A patient has second-degree burns on her right shoulder and first-degree burns on her right upper arm. For this burn scenario, you would report 943.25 (Blisters with epidural loss due to burn [second degree] of shoulder) for the shoulder burn and 943.13 (... erythema [first degree]; upper arm) for the upper arm burn -- in that order.

Example 2: A patient has second-degree burns on his right palm, the back of his hand and his thumb; the patient also has second-degree burns on his forearm.

For this scenario, you would report 944.28 (... blisters, epidermal loss [second degree]; multiple sites of wrist[s] and hand[s]) for the hand burns and 943.21 (... blisters, epidermal loss [second degree]; forearm) for the forearm burn.

Step 3: Look for TBSA Evidence in Notes

Whenever you can determine the total body surface area (TBSA) on a patient who suffers burns, you should include a secondary diagnosis code from the 948.xx code set, says Arnold.

"To report the correct 948 code, you must first select a fourth digit to indicate the percentage of TBSA burned. Then use a fifth digit to indicate what percentage of the total burned area is a third-degree," explains Arnold.

How do I calculate TBSA? In order to ensure you have properly measured the TBSA burned, you'll use the "Rule of Nines" when choosing your specific 948.xx code. According to the rule:

- head and neck, the right arm, and the left arm each equal 9 percent
- the back trunk, front trunk, left leg, and right leg each equal 18 percent (the front and back trunk are divided into upper and lower segments, and each leg is divided into back and front segments, each equaling 9 percent)
- genitalia equal 1 percent.

So let's say a patient suffers second- and third-degree burns to his front and back trunk (18 + 18 percent = 36 percent TBSA). Notes indicate that half of the burned area is third-degree (18 percent TBSA). On the claim you would report the following:

- 942.39 (Burn of trunk; full-thickness skin loss [third degree NOS]; other and multiple sites of trunk) for the trunk burns
- 948.31 (Burn [any degree] involving 30-39 percent of body surface with third degree burn of 10-19 percent) to represent the TBSA and amount of third-degree burns.

Also: The 948.xx code might be your only diagnosis if you cannot specify burn site, according to Linzer.